1. The utilization control committee of an acute hospital facility shall determine the medical necessity for admission and continued stay for all recipients. Extension of hospital stay shall be requested when a patient is awaiting placement in a long-term facility. Psychiatric inpatient care is limited to 40 days per calendar year.

2a. Outpatient psychiatric services are limited to one-hour individual and two-hour group therapy sessions. The number of visits are limited to 24 individual or 24 group therapy visits within a 12-month period or a combination of 6 individual and 24 group therapy visits or 6 group therapy and 24 individual visits within 12 months. Approval of a second and subsequent request shall be based on the severity of the patient's illness.

2c. FQHC services are congruent with the general scope and limitations to services of Hawaii's Medicaid Program.

2d. Coverage for pregnant women is limited to pregnancy related services, and to conditions which may complicate pregnancy, and family planning services during the postpartum period. Individuals under 18 years of age are entitled to all services under this Plan.

3. Payment for laboratory services made only for tests performed by standard procedures and techniques commonly accepted by the medical community.

4a. Authorization by the department's medical consultant is required for level of care and admission to a SNF.

4b. All services listed under section 1905(a) of the Social Security Act are available to EPSDT eligible individuals if the services are medically necessary, even though the services are not covered in this Plan. The services not covered in this Plan but which are available to EPSDT eligible individuals are as follows:

* Chiropractor services
* Private duty nursing
* Personal care
* Case management services

Furthermore, any limits on services or treatment found in this Plan are not applicable to EPSDT eligible individuals.

4c. The limitations on family planning are:

1) Hysterectomies are not covered when performed solely to render the person incapable of reproducing.

The individual under going a hysterectomy must be informed by the physician, prior to the procedure that the hysterectomy will render the individual incapable of reproducing. A signed acknowledgement is required.

2) Sterilizations are not authorized for any person under age 21 years; institutionalized; or mentally incompetent. Informed consent shall be obtained prior to a sterilization procedure.

Following the consent, the procedure may not be performed before 30 days and no later than 180 days. Some exceptions to this time limitation are allowed, i.e., premature delivery, abdominal surgery.

5a. Physicians' services are limited to two visits a month for patients in NF except for acute episodes. Physician services do not extend to procedures or services considered to be experimental or unproven as determined by Medicare.

5b. Periodontic treatment is limited to cases of medical necessity, includes in the procedure, post operative care for six months following treatment and recall treatment limited to three times a year. Prior authorization and a medical report is required. Osseous and mucogingival surgeries, grafts and implants are considered elective and are non-covered services.

Consultation and dental surgery are provided with the following limitations:

1) Routine post operative visits shall be considered part of the total surgical procedure and shall not be separately compensable; and
2) Vestibuloplastys, skin grafts, bone grafts, and metal implants shall not be covered except for fractured jaws.

6a. Exclusions to Podiatrist services are:

1) Routine foot care, including debridement not related to infection or injury.

2) Treatment of flat feet

3) Hospital inpatient services and appliances costing more than $50.00 require prior approval by the department.

6b. Approval required for contact lenses, subnormal visual aids costing not than $50.00 and to replace glasses or contacts within 2 years. Medical justification required for bifocal lenses prescribed for persons under 40 years of age.

Orthoptic training is excluded.

6d. Services of Psychologists are provided with the following limitations:

1) Testing is limited to a maximum or 4 hours once every 12 months or to 6 hours, if a comprehensive test is justified.

2) Prior authorization is required for all psychological testing except for tests that are requested by the department's professional staff.

7a to d. Home health services shall be reimbursed on the basis of "per visit"; Daily home visits permitted for home health aide and nursing services in the first two weeks of patient care if part of the written plan of care; No more than three visits per week for each service for the third week to the seventh week of care; No more than one visit a week for each service from the eight week to the fifteenth week of care; No more than one visit every other month for each service from the sixteenth week of care. Services exceeding these parameters shall be prior authorized by the medical consultant or it's authorized representative. Medical social services not covered.

Specific services subject to the limitations in providing those services as in #11.

Medical supplies, equipment and appliances require prior authorization by the department when the cost exceeds $50.00 per item.

Initial physical therapy and occupational therapy evaluations do not require prior approval. However, physical and occupational therapy and reevaluations require approval of the medical consultant providing diagnosis, recommended therapy including frequency and duration, and for chronic cases, long term goals and a plan of care.

All speech, hearing, and language evaluations and therapy require authorization by the medical consultant including rental ore purchase of hearing aids.

9. Clinical services, same limitations as #2 above.

10. Exclusions to dental services are:

(1) Orthodontic services, except following repair of cleft palate or other developmental defect or injury resulting in malalignment or malocclusion of the teeth in a child or when recommended by DOH's, crippled children branch.

(2) Fixed bridgework.

(3) Plaque control.

(4) Gold crowns and gold inlays.

(5) Procedures, appliances, or restoration solely for cosmetic purposes. Composite resin or acrylic restoration in posterior teeth and all primary teeth shall be considered purely cosmetic.

(6) Overdentures.

(7) Tooth preparation, temporary restorations, cement bases, impressions, or local anesthesia.

(8) Molar root canal therapy.

Limitations to dental services provided are:

(1) Dental services for individuals nineteen years and older who are not in foster care placement or in a subsidized adoption agreement are limited to emergency treatment which do not include services aimed at restoring or replacing teeth and shall include services for the following:

a. Relief of dental pain;

b. Elimination of infection; and

c. Treatment of acute injuries to the teeth or supporting structures of the oro-facial complex.

(2) X-rays with age limitations.

(3) Dental work done under intravenous, inhalation or general anesthesia shall be allowed only once per treatment plan and limited to cases of medical necessity.

(4) Restorative dentistry limited to use of certain materials. Non-duplicated restorative procedure are allowed once per tooth every two years as needed in treatment of fractured per carious teeth.

(5) Dental prostheses:

a. Partial dentures limited to fill space due to loss of one or more anterior teeth.

b. One partial and full dentures shall be allowed per arch per recipient in any five year period. This is allowed only when existing dentures cannot be repaired or adjusted.

c. Temporary, interim, or immediate dentures allowed only when teeth have been recently extracted and shall be subject to maximum benefit for dentures and authorization.

d. Dentures relines are limited to once per denture every two years.

(6) Topical application of fluoride is limited to children up to age eighteen, once every six months.

(7) Sealants for occlusal surface of caries free permanent molar teeth only for children age six through fifteen.

(8) Root canal therapy shall be covered for a maximum of once per tooth, except in cases of poor prognosis, as in the case of advanced decay or bone loss or prior root canal failure. Molar endodontic therapy is not covered.

(9) Acrylic jackets and acrylic veneer crowns, if authorized, shall be limited to anterior teeth for a maximum of once per tooth.

(10) Except for emergency treatments, prior authorization is required for certain dental work.

(11a to c) Physical and occupational therapy and services for speech, hearing and language disorders are limited to patients who are expected to improve in a reasonable period of time with therapy. Prior authorization is required.

12a. Prescribed drugs must be listed in the Hawaii Medicaid Drug Formulary: all other prescribed drugs require prior authorization.

(1) Only those drugs rated 1-A or 1-AA or non-participating manufactures in compliance with Section 1927(a)(3)(A)(ii) of the Act and those drug products produced by manufactures who have entered into and comply with an agreement under Section 1927(a) of the Act are payable by being listed in the Hawaii Medicaid Drug Formulary or by prior authorization, except those drugs:

(a) Used for cosmetic purposes or hair growth;

(b) With associated tests or monitoring purchased exclusively from the manufacturer or designee as a condition of sale;

(c) Which are classed as "less than effective" as described in Section 107(c)(3) of the Drug Amendments of 1962 or are identical, similar or related; and

(d) Used to promote fertility.

(2) The following drugs or classes of drugs, produced by manufactures complying with Section 1927(a) of the Act, or their medical uses will be selectively covered as decided by the Advisory Medicaid Formulary Committee (the responsibilities for which have been delegated to the State Drug Use Review Board);

(a) Agents used for the symptomatic relief of cough and colds;

(b) Vitamins and mineral products except prenatal and fluoride preparations;

(c) Non-prescription drugs;

(d) Barbiturates;

(e) Benzodiazepines; and

(f) Agents used for anorexia or weight gain.

(3) The State will not enter into any separate or any rebate agreements without amendment to the State Plan nor without reporting any rebates received from any separate agreements. Any possible future rebate agreement will be submitted to the Health Care Financing Administration (HCFA) for approval implementation.

(4) Prior authorization imposed on any covered outpatient drug will meet the following conditions:

(a) Prior authorization requests will be responded to within 24 hours of receipt by telephone or other telecommunication; and

(b) In an emergency, a seventy-two hour supply of the drug desired by the prescribing physician will be allowed (an emergency is defined as a situation that exists when the withholding of the medication chosen by the prescribing physician will cause the patient's medical condition to worsen or prevent

improvement and the person designated to approve prior authorization is not available for approval by telephone or other means). The State will ensure that it responds to a prior authorization request before the emergency supply is exhausted.

(5) The maximum quantity of any medication to be paid equals the larger of a one month supply or one hundred units.

(6) In compliance with Section 1927(b)(2) of the Social Security Act, the fiscal agent is engaged to report to each manufacturer not later than sixty days after the end of each calendar quarter and in a form consistent with a standard reporting format established by the Secretary, information on the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter and shall promptly transmit a copy of such report to the Secretary as instructed by HCFA.

12b. Partial dentures limited to fill the space due to the loss of one or more anterior teeth and to fill the space due to the loss of two or more posterior teeth exclusive of third molars. Temporary dentures allowed only when teeth have been extracted recently with prior authorization and subject to maximums or prosthetics.

Only one prosthetic appliances in any five year period is allowed for a maximum of one for each type, partial and full dentures, per arch per recipient; lifetime. This is allowed when present or previous dentures cannot be repaired or adjusted.

12c. Prosthetic devices require prior authorization when the cost of purchase, repair or manufacture exceeds $50.00.